2009 – 2010 LEGISLATURE

LRB–0376/P1
TJD:wlj:ph

In 1/14/09

DOA:.....Willing, BB0090 – Family care eligibility and expansion, disability ombudsman, intensive treatment program charge–backs, rule–making changes

FOR 2009–11 BUDGET –– NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

LONG–TERM CARE

This is a preliminary draft. An analysis will be provided in a subsequent version.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 16.009 (2) (p) (intro.) of the statutes is amended to read:

16.009 **(2)** (p) (intro.) Employ staff within the classified service or contract with one or more organizations to provide advocacy services to potential or actual recipients of the family care benefit, as defined in s. 46.2805 (4), or of an integrated benefit, as defined in s. 46.2805 (7h), or their families or guardians. The board and

contract organizations under this paragraph shall assist these persons in protecting their rights under all applicable federal statutes and regulations and state statutes and rules. An organization with which the board contracts for these services may not be a provider, nor an affiliate of a provider, of long–term care services, a resource center under s. 46.283 or a care management organization under s. 46.284. For potential or actual recipients of the family care benefit or an integrated benefit, advocacy services required under this paragraph shall include all of the following:

SECTION 2. 16.009 (2) (p) 5. of the statutes is amended to read:

16.009 **(2)** (p) 5. Providing individual case advocacy services in administrative hearings and legal representation for judicial proceedings regarding family care services or benefits or an integrated benefit.

SECTION 3. 20.435 (7) (g) of the statutes is amended to read:

20.435 **(7)** (g) *Long–term care; county contributions.* All moneys received from counties as contributions to the family care program under s. 46.2805 to 46.2895, the ~~Pace program~~ Program of All–Inclusive Care for the Elderly, as described under s. ~~46.2805 (1) (a)~~ 46.2805 (9m), and the Wisconsin Partnership Program described under s. ~~46.2805 (1) (b)~~ 46.2805 (15), to fund services under the family care benefit under s. 46.284 (5) and services under the ~~Pace~~ Program of All–Inclusive Care for the Elderly and the Wisconsin Partnership ~~programs~~ Program.

SECTION 4. 46.2803 (2) of the statutes is amended to read:

46.2803 **(2)** Notwithstanding s. 46.27 (7), a county in which a care management organization is operating pursuant to a contract under s. 46.284 (2) or a county in which a program described under s. ~~46.2805 (1) (a) or (b)~~ 46.2805 (9m) or (15) is administered may use funds appropriated under 20.435 (7) (bd) and allocated to the county under s. 46.27 (7) to provide community mental health or substance abuse

services and supports for persons with mental illness or persons in need of services or supports for substance abuse and to provide services under the Family Support Program under s. 46.985.

SECTION 5. 46.2805 (1) (intro.) of the statutes is renumbered 46.2805 (1) and amended to read:

46.2805 **(1)** "Care management organization" means an entity that is certified as meeting the requirements for a care management organization under s. 46.284 (3) and that has a contract under s. 46.284 (2). ~~"Care management organization" does not mean an entity that contracts with the department or a contract to operate one of the following:~~ to provide the family care benefit, an integrated benefit, or both.

SECTION 6. 46.2805 (1) (a) of the statutes is repealed.

SECTION 7. 46.2805 (1) (b) of the statutes is repealed.

SECTION 8. 46.2805 (7h) of the statutes is created to read:

46.2805 **(7h)** "Integrated benefit" means financial assistance for long–term care and support items, along with financial assistance for either acute or primary medical care or both for an enrollee.

SECTION 9. 46.2805 (9m) of the statutes is created to read:

46.2805 **(9m)** "Program of All–Inclusive Care for the Elderly" means the program operated under 42 USC 1395eee or 1396u–4 providing an integrated benefit.

SECTION 10. 46.2805 (15) of the statutes is created to read:

46.2805 **(15)** "Wisconsin Partnership Program" means a Medical Assistance demonstration program providing an integrated benefit.

****NOTE: Please confirm whether this is the appropriate way to refer to the Wisconsin Partnership Program.

SECTION 11. 46.281 (1d) of the statutes is amended to read:

46.281 **(1d)** WAIVER REQUEST. The department shall request from the secretary of the federal department of health and human services any waivers of federal medicaid laws necessary to permit the use of federal moneys to provide the family care benefit or an integrated benefit to recipients of medical assistance. The department shall implement any waiver that is approved and that is consistent with ss. 46.2805 to 46.2895. Regardless of whether a waiver is approved, the department may implement operation of resource centers, care management organizations, ~~and~~ the family care benefit, and an integrated benefit.

****NOTE: Would you like to repeal s. 46.281 (1d) as obsolete since the waiver has been obtained and implemented?

SECTION 12. 46.281 (1g) (a) of the statutes is amended to read:

46.281 **(1g)** (a) Subject to par. (b), the department may contract with entities as provided under s. 46.283 (2) to provide the services under s. 46.283 (3) and (4) as resource centers in any geographic area in the state, and may contract with entities as provided under s. 46.284 (2) to administer the family care benefit, an integrated benefit, or both as care management organizations in any geographic area in the state.

SECTION 13. 46.281 (1g) (b) of the statutes is amended to read:

46.281 **(1g)** (b) If the department proposes to contract with entities to administer the family care benefit or an integrated benefit in geographic areas in which, in the aggregate, resides more than 29 percent of the state population that is eligible for the family care benefit or an integrated benefit, the department shall first notify the joint committee on finance in writing of the proposed contract. The notification shall include the contract proposal~~;~~ and an estimate of the fiscal impact

of the proposed addition that demonstrates that the addition will be cost neutral, including startup, transitional, and ongoing operational costs and any proposed county contribution. The notification shall also include, for each county affected by the proposal, documentation that the county consents to administration of the family care benefit, an integrated benefit, or both in the county, the amount of the county's payment or reduction in community aids under s. 46.281 (4), and a proposal by the county for using any savings in county expenditures on long–term care that result from administration of the family care benefit or integrated benefit in the county. If the cochairpersons of the committee do not notify the department within 14 working days after the date of the department's notification that the committee has scheduled a meeting for the purpose of reviewing the proposed contract, the department may enter into the proposed contract. If within 14 working days after the date of the department's notification the cochairpersons of the committee notify the department that the committee has scheduled a meeting for the purpose of reviewing the proposed contract, the department may enter into the proposed contract only if the committee approves the proposed contract or if the committee fails to act on the proposed contract within 59 working days after the date of the department's notification.

SECTION 14. 46.281 (1n) (a) of the statutes is amended to read:

46.281 **(1n)** (a) Prescribe and implement a per person monthly rate structure for costs of the family care benefit and an integrated benefit.

SECTION 15. 46.281 (1n) (b) 3. of the statutes is amended to read:

46.281 **(1n)** (b) 3. Conduct ongoing evaluations of managed care programs for provision of long–term care services that are funded by medical assistance, as defined in s. 46.278 (1m) (b), as to client access to services, the availability of client

choice of living and service options, quality of care, and cost–effectiveness. In evaluating the availability of client choice, the department shall evaluate the opportunity for a client to arrange for, manage, and monitor his or her family care benefit or integrated benefit directly or with assistance, as specified in s. 46.284 (4) (e).

SECTION 16. 46.281 (1n) (b) 4. of the statutes is amended to read:

46.281 **(1n)** (b) 4. Require that quality assurance and quality improvement efforts be included throughout ~~the long–term care system specified in ss. 46.2805 to 46.2895~~ family care benefit or integrated benefit services.

SECTION 17. 46.281 (1n) (c) of the statutes is amended to read:

46.281 **(1n)** (c) Require by contract that resource centers and care management organizations establish procedures under which an individual who applies for or receives the family care benefit or an integrated benefit may register a complaint or grievance and procedures for resolving complaints and grievances.

SECTION 18. 46.281 (1n) (e) of the statutes is amended to read:

46.281 **(1n)** (e) Contract with a person to provide the advocacy services described under s. 16.009 (2) (p) 1. to 5. to actual or potential recipients of the family care benefit or an integrated benefit who are under age 60 or to their families or guardians. The department may not contract under this paragraph with a county or with a person who has a contract with the department to provide services under s. 46.283 (3) and (4) as a resource center or to administer the family care benefit or an integrated benefit as a care management organization. The contract under this paragraph shall include as a goal that the provider of advocacy services provide one advocate for every ~~2,500~~ 3,500 individuals under age 60 who receive the family care or an integrated benefit. ~~The department shall allocate $190,000 for the contract~~

~~under this paragraph in fiscal year 2007–08 and $525,000 in each subsequent fiscal year.~~

SECTION 19. 46.2825 (2) (a) of the statutes is amended to read:

46.2825 **(2)** (a) Evaluate the performance of care management organizations ~~and entities that operate a program described under s. 46.2805 (1) (a) or (b)~~ in the committee's region with respect to responsiveness to recipients of their services, fostering choices for recipients, and other issues affecting recipients; and make recommendations based on the evaluation to the department and to the care management organizations and entities, as appropriate.

SECTION 20. 46.2825 (2) (c) of the statutes is amended to read:

46.2825 **(2)** (c) Monitor grievances and appeals made to care management organizations ~~or entities that operate a program described under s. 46.2805 (1) (a) or (b)~~ within the committee's region.

SECTION 21. 46.283 (1) (a) 1. of the statutes is amended to read:

46.283 **(1)** (a) 1. Whether to authorize one or more county departments under s. 46.21, 46.215, 46.22 or 46.23 or an aging unit under s. 46.82 (1) (a) 1. or 2. to apply to the department for a contract to operate a resource center and, if so, which to authorize ~~and~~, what client group to serve, and whether to provide the family care benefit, an integrated benefit, or both.

SECTION 22. 46.283 (3) (f) of the statutes is amended to read:

46.283 **(3)** (f) Assistance to a person who is eligible for the family care benefit or an integrated benefit with respect to the person's choice of whether ~~or not~~ to enroll in a care management organization and, if so, which available care management organization would best meet his or her needs.

SECTION 23. 46.283 (4) (e) of the statutes is amended to read:

46.283 **(4)** (e) Provide information about the services of the resource center, including the services specified in sub. (3) (d), about assessments under s. 46.284 (4) (b) and care plans under s. 46.284 (4) (c) and about the family care benefit and an integrated benefit, if available in the area, to all older persons and persons with a physical disability who are residents of nursing homes, community–based residential facilities, adult family homes, and residential care apartment complexes in the area of the resource center.

SECTION 24. 46.283 (6) (a) 3. of the statutes is amended to read:

46.283 **(6)** (a) 3. An individual who has a financial interest in, or serves on the governing board of, a care management organization ~~or an organization that administers a program described under s. 46.2805 (1) (a) or (b)~~ or a managed care program under s. 49.45 for individuals who are eligible to receive supplemental security income under 42 USC 1381 to 1383c, which serves any geographic area also served by a resource center, and the individual's family members, may not serve as members of the governing board of the resource center.

SECTION 25. 46.284 (1) (a) 1. of the statutes is amended to read:

46.284 **(1)** (a) 1. Whether to authorize one or more county departments under s. 46.21, 46.215, 46.22 or 46.23 or an aging unit under s. 46.82 (1) (a) 1. or 2. to apply to the department for a contract to operate a care management organization and, if so, which to authorize ~~and~~, what client group to serve, and whether to provide the family care benefit, an integrated benefit, or both.

SECTION 26. 46.284 (1) (b) of the statutes is amended to read:

46.284 **(1)** (b) The governing body of a tribe or band or of the Great Lakes Inter–Tribal Council, Inc., may decide whether to authorize a tribal agency to apply to the department for a contract to operate a care management organization for tribal

members and, if so, which client group to serve and whether to provide the family care benefit, an integrated benefit, or both.

SECTION 27. 46.284 (2) (c) of the statutes is renumbered 46.284 (2) (c) (intro.) and amended to read:

46.284 **(2)** (c) (intro.) The department shall require, as a term of any contract with a care management organization under this section, ~~that~~ all of the following:

2. That the care management organization contract for the provision of long–term care services that are covered under the family care or integrated benefit with any community–based residential facility under s. 50.01 (1g), residential care apartment complex under s. 50.01 (1d), nursing home under s. 50.01 (3), intermediate care facility for the mentally retarded under s. 50.14 (1) (b), community rehabilitation program, home health agency under s. 50.49 (1) (a), provider of day services, or provider of personal care, as defined in s. 50.01 (4o), that agrees to accept the reimbursement rate that the care management organization pays under contract to similar providers for the same service and that satisfies any applicable quality of care, utilization, or other criteria that the care management organization requires of other providers with which it contracts to provide the same service.

SECTION 28. 46.284 (2) (c) 1. of the statutes is created to read:

46.284 **(2)** (c) 1. That the care management organization designate whether it provides the family care benefit, an integrated benefit, or both.

SECTION 29. 46.284 (2) (c) 3. of the statutes is created to read:

46.284 **(2)** (c) 3. That the care management organization contract for the provision of acute and primary care services covered under an integrated benefit with a provider that agrees to accept the reimbursement rate the care management organization pays under contract to similar providers for the same service and that

satisfies any applicable quality of care, utilization, or other criteria the care management organization requires of other providers with which it contracts to provide the same service.

SECTION 30. 46.284 (4) (a) of the statutes is amended to read:

46.284 **(4)** (a) Accept requested enrollment of any person who is entitled to the family care benefit and of any person for whom funding is available and who is eligible for the family care benefit or an integrated benefit, whichever the care management organization is contracted to provide, ~~and for whom funding is available~~. No care management organization may disenroll any enrollee, except under circumstances specified by the department by contract. No care management organization may encourage any enrollee to disenroll in order to obtain long–term care services under the medical assistance fee–for–service system. No involuntary disenrollment is effective unless the department has reviewed and approved it.

move stricken text

****NOTE: Please note that I have treated only family care as an entitlement for certain individuals. I am presuming that an integrated benefit would not be an entitlement. If you would like to make an integrated benefit an entitlement I can make the change here and to s. 46.286 (3).

SECTION 31. 46.284 (4) (e) of the statutes is amended to read:

46.284 **(4)** (e) Provide, within guidelines established by the department, a mechanism by which an enrollee may arrange for, manage, and monitor his or her family care benefit or an integrated benefit directly or with the assistance of another person chosen by the enrollee. The care management organization shall provide each enrollee with a form on which the enrollee shall indicate whether he or she has been offered the option under this paragraph and whether he or she has accepted or declined the option. If the enrollee accepts the option, the care management organization shall monitor the enrollee's use of a fixed budget for purchase of services or support items from any qualified provider, monitor the health and safety of the

enrollee, and provide assistance in management of the enrollee's budget and services at a level tailored to the enrollee's need and desire for the assistance.

SECTION 32. 46.284 (4) (f) of the statutes is amended to read:

46.284 **(4)** (f) Provide, on a fee–for–service basis, case management services to persons who are functionally eligible but not financially eligible for the family care benefit or an integrated benefit.

SECTION 33. 46.284 (5) (a) of the statutes is amended to read:

46.284 **(5)** (a) From the appropriation accounts under s. 20.435 (4) (b), (g), (gp), (im), (o), and (w) and (7) (b), (bd), and (g), the department shall provide funding on a capitated payment basis for the provision of services under this section. Notwithstanding s. 46.036 (3) and (5m), a care management organization that is under contract with the department may expend the funds, consistent with this section, including providing payment, on a capitated basis, to providers of services under the family care benefit or an integrated benefit.

SECTION 34. 46.284 (5) (d) 4. of the statutes is amended to read:

46.284 **(5)** (d) 4. The requirement that a care management organization place funds in a risk reserve and maintain the risk reserve in an interest–bearing escrow account with a financial institution, as defined in s. 69.30 (1) (b), or invest funds as specified in s. 46.2895 (4) (j) 2. or 3. Moneys in the risk reserve or invested as specified in this subdivision may be expended only for the provision of services under this section. If a care management organization ceases participation under this section, the funds in the risk reserve or invested as specified in this subdivision, minus any contribution of moneys other than those specified in par. (c), shall be returned to the department. The department shall expend the moneys for the payment of outstanding debts to providers of family care benefit or integrated benefit services

and for the continuation of family care benefit and integrated benefit services to enrollees.

SECTION 35. 46.284 (5) (e) 1. of the statutes is amended to read:

46.284 **(5)** (e) 1. Subject to subd. 2., a care management organization may enter into contracts with providers of family care benefit or integrated benefit services and may limit profits of the providers under the contracts.

SECTION 36. 46.286 (title) of the statutes is amended to read:

46.286 (title) **Family care benefit and integrated benefit.**

SECTION 37. 46.286 (1) (title) of the statutes is repealed and recreated to read:

46.286 **(1)** (title) FAMILY CARE ELIGIBILITY.

SECTION 38. 46.286 (1) (a) (intro.) and 46.286 (1) (a) 1. (intro.) of the statutes are consolidated, renumbered 46.286 (1) (a) (intro.) and amended to read:

46.286 **(1)** (a) *Functional eligibility.* (intro.) A person is functionally eligible if ~~any of the following applies~~ the person's level of care need, as determined by the department or its designee~~: 1. (intro.) The person's level of care need,~~ is either of the following:

SECTION 39. 46.286 (1) (a) 1. a. of the statutes is renumbered 46.286 (1) (a) 1m.

SECTION 40. 46.286 (1) (a) 1. b. of the statutes is renumbered 46.286 (1) (a) 2m.

SECTION 41. 46.286 (1) (a) 2. (intro.) of the statutes is repealed.

SECTION 42. 46.286 (1) (a) 2. a. of the statutes is renumbered 46.286 (3) (b) 2. a.

SECTION 43. 46.286 (1) (a) 2. b. of the statutes is renumbered 46.286 (3) (b) 2. b.

SECTION 44. 46.286 (1) (a) 2. c. of the statutes is renumbered 46.286 (3) (b) 2. c.

SECTION 45. 46.286 (1) (a) 2. d. of the statutes is renumbered 46.286 (3) (b) 2. d.

SECTION 46. 46.286 (1) (a) 2. e. of the statutes is renumbered 46.286 (3) (b) 2. e.

****NOTE: Please note that I have left the eligibility portion so it addresses only family care. If you would like eligibility provisions for Pace and partnership added, please let me know.

SECTION 47. 46.286 (2) (a) of the statutes is amended to read:

46.286 **(2)** (a) A person who is determined to be financially eligible ~~under sub. (1) (b)~~ for family care, the Program of All–Inclusive Care for the Elderly, or the Wisconsin Partnership Program shall contribute to the cost of his or her care an amount that is calculated by the department or its designee after subtracting from the person's gross income, plus one–twelfth of countable assets, the deductions and allowances permitted by the department by rule.

SECTION 48. 46.286 (2) (b) of the statutes is amended to read:

46.286 **(2)** (b) Funds received under par. (a) shall be used by a care management organization to pay for services under the family care benefit, the Program of All–Inclusive Care for the Elderly, or the Wisconsin Partnership Program from whichever program the person is receiving services.

SECTION 49. 46.286 (2) (c) of the statutes is amended to read:

46.286 **(2)** (c) A person who is required to contribute to the cost of his or her care but who fails to make the required contributions is ineligible for the family care benefit, the Program of All–Inclusive Care for the Elderly, and the Wisconsin Partnership Program unless he or she is exempt from the requirement under rules promulgated by the department.

SECTION 50. 46.286 (3) (title) of the statutes is repealed and recreated to read:

46.286 **(3)** (title) FAMILY CARE ENTITLEMENT.

SECTION 51. 46.286 (3) (b) 2. of the statutes is renumbered 46.286 (3) (b) 2. (intro.) and amended to read:

46.286 **(3)** (b) 2. (intro.) If the contract between the care management organization and the department is canceled or not renewed. If this circumstance occurs, the department shall assure that enrollees continue to receive needed services through another care management organization or through the medical assistance fee–for–service system or any of the following programs ~~specified under sub. (1) (a) 2. a. to d.~~:

Insert 14-10

SECTION 52. 46.286 (3m) of the statutes is amended to read:

46.286 **(3m)** INFORMATION ABOUT ENROLLEES. The department shall obtain and share information about family care benefit and integrated benefit enrollees as provided in s. 49.475.

SECTION 53. 46.286 (4) of the statutes is amended to read:

46.286 **(4)** DIVESTMENT; RULES. The department shall promulgate rules, which are substantially similar to applicable provisions under s. 49.453, relating to prohibitions on divestment of assets of persons who receive the family care benefit~~, that are substantially similar to applicable provisions under s. 49.453~~ or an integrated benefit.

SECTION 54. 46.286 (5) of the statutes is amended to read:

46.286 **(5)** TREATMENT OF TRUST AMOUNTS; RULES. The department shall promulgate rules, which are substantially similar to applicable provisions under s. 49.454, relating to treatment of trust amounts of persons who receive the family care benefit~~, that are substantially similar to applicable provisions under s. 49.454~~ or an integrated benefit.

SECTION 55. 46.286 (6) of the statutes is amended to read:

46.286 **(6)** PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE; RULES. The department shall promulgate rules, which are substantially similar to applicable provisions under ss. 49.455 relating to protection of income and resources of couples for the maintenance of the spouse in the community with regard to persons who receive the family care benefit, ~~that are substantially similar to applicable provisions under s. 49.455~~ or an integrated benefit.

SECTION 56. 46.286 (7) of the statutes is amended to read:

46.286 **(7)** RECOVERY OF FAMILY CARE BENEFIT PAYMENTS; RULES. The department shall promulgate rules, which are substantially similar to applicable provisions under ss. 49.496 and 49.497 relating to the recovery from persons who receive the family care benefit, including by liens and from estates, of correctly and incorrectly paid family care benefits and integrated benefits, ~~that are substantially similar to applicable provisions under ss. 49.496 and 49.497~~ or an integrated benefit.

LPS: This seems to be fixed in the electronic version.

SECTION 57. 46.287 (1) of the statutes is amended to read:

46.287 **(1)** DEFINITION. In this section, "client" means a person applying for eligibility for the family care benefit or an integrated benefit, an eligible person, or an enrollee.

SECTION 58. 46.287 (2) (a) 1. e. of the statutes is amended to read:

46.287 **(2)** (a) 1. e. Reduction of services or support items under the family care benefit or an integrated benefit.

SECTION 59. 46.287 (2) (a) 1. g. of the statutes is amended to read:

46.287 **(2)** (a) 1. g. Termination of the family care benefit or an integrated benefit.

SECTION 60. 46.287 (2) (a) 1. h. of the statutes is amended to read:

46.287 **(2)** (a) 1. h. Imposition of ineligibility for the family care benefit or an integrated benefit under s. 46.286 (4).

SECTION 61. 46.287 (2) (a) 1. k. of the statutes is amended to read:

46.287 **(2)** (a) 1. k. Recovery of family care benefit or integrated benefit payments under s. 46.286 (7).

SECTION 62. 46.288 (2) (intro.) of the statutes is amended to read:

46.288 **(2)** (intro.) Criteria and procedures for determining functional eligibility under s. 46.286 (1) (a), financial eligibility under s. 46.286 (1) (b), and cost sharing under s. 46.286 (2) (a). The rules for determining functional eligibility under s. 46.286 (1) (a) ~~1. a.~~ 1m. shall be substantially similar to eligibility criteria for receipt of the long–term support community options program under s. 46.27. Rules under this subsection shall include definitions of the following terms applicable to s. 46.286:

SECTION 63. 46.288 (2) (a) of the statutes is repealed.

SECTION 64. 46.288 (2) (b) of the statutes is repealed.

SECTION 65. 46.288 (2) (c) of the statutes is repealed.

SECTION 66. 46.2895 (1) (a) 1. b. of the statutes is amended to read:

46.2895 **(1)** (a) 1. b. Specifies the long–term care district's primary purpose, which shall be to operate, under contract with the department, a resource center under s. 46.283, or a care management organization under s. 46.284~~, or a program described under s. 46.2805 (1) (a) or (b)~~.

SECTION 67. 46.2895 (1) (c) of the statutes is amended to read:

46.2895 **(1)** (c) A long–term care district may not operate a care management organization under s. 46.284 ~~or a program described under s. 46.2805 (1) (a) or (b)~~ if the district operates a resource center under s. 46.283.

SECTION 68. 46.2895 (4) (b) of the statutes is amended to read:

46.2895 **(4)** (b) Adopt bylaws and policies and procedures for the regulation of its affairs and the conduct of its business. The bylaws, policies and procedures shall be consistent with ss. 46.2805 to 46.2895 and, if the long–term care district contracts with the department under par. (d) ~~or (dm)~~, with the terms of that contract.

SECTION 69. 46.2895 (4) (dm) of the statutes is repealed.

SECTION 70. 46.2895 (4) (e) of the statutes is amended to read:

46.2895 **(4)** (e) Provide services related to services available under the family care benefit or an integrated benefit, to older persons and persons with disabilities, in addition to the services funded under the contract with the department that is specified under par. (d).

SECTION 71. 46.2895 (6) (c) of the statutes is amended to read:

46.2895 **(6)** (c) Assure compliance with the terms of any contract with the department under. sub. (4) (d) ~~or (dm)~~.

SECTION 72. 49.45 (30m) (am) of the statutes is renumbered 49.45 (30m) (am) 1.

SECTION 73. 49.45 (30m) (am) 2. of the statutes is created to read:

49.45 **(30m)** (am) 2. For individuals receiving the family care benefit under s. 46.286, the care management organization that manages the family care benefit for the recipient shall pay the portion of the payment that is not covered by the federal government for services that are described under par. (a) 1. and are covered services under the family care benefit; the department shall pay the remainder of the portion of the payment that is not covered by the federal government.

SECTION 74. 49.475 (1) (e) 2. of the statutes is amended to read:

49.475 **(1)** (e) 2. An enrollee of family care, the Program of All–Inclusive Care for the Elderly, as defined in s. 46.2805 (9m), or the Wisconsin Partnership Program, as defined in s. 46.2805 (15).

SECTION 75. 50.49 (6m) (b) of the statutes is repealed.

SECTION 76. 50.49 (6m) (c) of the statutes is repealed.

SECTION 77. 51.437 (4rm) (d) of the statutes is created to read:

51.437 **(4rm)** (d) Notwithstanding pars. (a) to (c), for individuals receiving the family care benefit under s. 46.286, the care management organization that manages the family care benefit for the recipient shall pay the portion of the payment that is not covered by the federal government for services that are covered services under the family care benefit; the department shall pay the remainder of the portion of the payment that is not covered by the federal government.

****NOTE: Is the addition of this paragraph sufficient? If you feel that each paragraph under s. 51.437 (4rm) needs to be amended, please let me know more specifically what services and payments need to be addressed.

(END)

Insert 18-13

INSERT A

Under current law, in certain counties, a person who meets certain functional and financial criteria and who is either is a frail elder or a person who is at least 18 years old with a physical disability or a developmental disability is eligible for and may obtain the family care benefit. The family care benefit is financial assistance for long-term care.

Also, currently, an individual ~~who does not~~ meet the functional eligibility requirements for the family care benefit but who (1) has a condition that is expected to last at least 90 days or result in death within 12 months, (2) applies within 36 months after the date on which the family care benefit is available in the individual's county of residence, and (3) on the date the family care benefit became available in the individual's county of residence, was a resident of a nursing home or had been receiving long-term care services under certain programs for at least 60 days ~~may~~ be eligible for the family care benefit. This bill eliminates this provision allowing some individuals to be grandfathered into the family care benefit and requires that all individuals meet the functional eligibility requirements to be eligible for family care.

Under current law, ~~certain individuals may be entitled to the family care~~ benefit. DHS must ensure that care management organizations have the capacity to provide the family care benefit to all ~~entitled~~ persons in the county within 24 months. The bill lengthens the time for ensuring the entitled benefit to 36 months.

Currently, a resource center in a county provides information on the family care benefit to certain individuals, provides functional and financial eligibility screenings to potential family care enrollees, and refers potential family care enrollees to a care management organization. A care management organization administers the family care benefit under a contract with DHS.

The bill allows care management organizations to administer either the Program of All-Inclusive Care for the Elderly (PACE) or the Wisconsin Partnership Program (Partnership) or both in place of or in addition to the family care benefit. PACE and Partnership offer an integrated benefit, ~~which~~ is financial assistance for long-term care and support items, along with financial assistance for either acute or primary medical care or both. ~~In~~ the bill, individuals obtaining the integrated benefit through PACE and Partnership have responsibilities, rights, and benefits similar to family care enrollees such as contributing to the cost of care according to a formula; complying with divestment and trust rules; and contesting certain matters through a hearing process.

The bill imposes requirements on DHS, resource centers, care management organizations, and long-term care districts with respect to administration and implementation of the integrated benefit that are similar to the current requirements for administration and implementation of the family care benefit. For

DHS these requirements include implementing a per person monthly rate structure for the costs of the integrated benefit; evaluating the client's opportunity to arrange for, manage, and monitor the integrated benefit; extending quality improvement efforts to the integrated benefit; and ensuring that resource centers and care management organizations establish procedures so an integrated benefit applicant or enrollee may register a grievance. Resource centers must provide information about the integrated benefit and referral services to individuals who are potentially eligible for the integrated benefit. Care management organizations must designate whether they provide the integrated benefit, the family care benefit, or both; accept the reimbursement rate for the integrated benefit, if provided; contract for provision of acute and primary care services with a provider that agrees to accept the reimbursement rate; accept enrollment of a person eligible for the integrated benefit for whom funding is available; provide for the integrated benefit enrollee to manage and monitor the benefit; provide fee-for-service case management service for those who are functionally but not financially eligible for an integrated benefit; and fulfill additional requirements. A long-term care district may provide services related to services available under an integrated benefit. The long-term care district has duties including assuring compliance with the terms of a contract with a care management organization or a resource center. This bill does not eliminate any requirements for DHS, resource centers, care management organizations, or long-term care districts with respect to administration and implementation of family care.

Under current law, the Board on Aging and Long-Term Care must contract to provide advocacy services to actual or potential recipients of the family care benefit in a ratio of one advocate to every 2,500 individuals under age 60 who receive the family care benefit. DHS must allot $525,000 for the contract to provide advocacy services in each fiscal year. This bill decreases the ratio to one advocate to every 3,500 individuals under age 60 who receive either family care or the integrated benefit through PACE or Partnership. The bill eliminates the requirement for DHS to allot money for the contract.

Under current law, the county pays for services for a developmentally disabled individual if those services are not paid for by the federal government. The county also pays for certain mental health services that are not paid for by the federal government. If the individual receiving services is eligible for medical assistance, DHS will pay for the services not paid for by the federal government. The bill requires that, for individuals receiving the family care benefit, the care management organization pay for services ~~including mental health services covered by family care,~~ provided to developmentally disabled individuals, ~~and~~ not paid for by the federal government.

INSERT 14-10

SECTION 1. 46.286 (3) (c) of the statutes is amended to read:

46.286 **(3)** (c) Within each county and for each client group, par. (a) shall first apply on the effective date of a contract under which a care management organization accepts a per person per month payment to provide services under the family care benefit to eligible persons in that client group in the county. Within ~~24~~ 36 months after this date, the department shall assure that sufficient capacity exists within one or more care management organizations to provide the family care benefit to all entitled persons in that client group in the county.

History: 1999 a. 9, 185; 2001 a. 16, 109; 2003 a. 33; 2005 a. 25, 264, 388; 2007 a. 20.

INSERT 18-13

SECTION 9322. Initial applicability; Health Services.

(1) FAMILY CARE ENTITLEMENT. The treatment of section 46.286 (3) (c) of the statutes first applies to care management organizations that implement the family care benefit on January 1, 2008.

Dodge, Tamara

From: Fox, Sabrina E - DOA [Sabrina.Fox@wisconsin.gov]
Sent: Wednesday, January 21, 2009 10:04 AM
To: Dodge, Tamara
Subject: FW: LRB Draft: 09-0376/P2 Family care eligibility and expansion, disability ombudsman, intensive treatment program charge-backs, rule-making changes
Attachments: 09-0376/P2.pdf

Hi Tami:
I have an additional change to be made to this draft.

The Department's request to apply the family care statutes to all managed long term care programs was denied and therefore, the changes in this draft made to reflect that request need to be removed. Current law excludes managed long term care programs that also integrate primary and acute care, Partnership and PACE from provisions – and the decision was made to continue to exclude them from family care statutes, therefore denying the Department's request to include them. All other items included in this draft were approved and can remain included. I have sent the new draft over to the department for their final review. If I get any additional changes, I will forward them on to you.

Please let me know if you have any questions.

Thanks,
Sabrina

From: Willing, Krista - DOA
Sent: Tuesday, January 20, 2009 11:16 AM
To: Fox, Sabrina E - DOA
Subject: FW: LRB Draft: 09-0376/P2 Family care eligibility and expansion, disability ombudsman, intensive treatment program charge-backs, rule-making changes

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From: Duchek, Michael [mailto:Michael.Duchek@legis.wisconsin.gov]
Sent: Tuesday, January 20, 2009 10:57 AM
To: Willing, Krista - DOA
Cc: Gauger, Michelle C - DOA; Hanaman, Cathlene - LEGIS; Beadles, Kathleen - DOA
Subject: LRB Draft: 09-0376/P2 Family care eligibility and expansion, disability ombudsman, intensive treatment program charge-backs, rule-making changes

Following is the PDF version of draft 09-0376/P2.

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-0376/P2
TJD:wlj:md

In: 1/23/09

DOA:.....Willing, BB0090 – Family care eligibility and expansion, disability ombudsman, intensive treatment program charge-backs, rule-making changes

FOR 2009-11 BUDGET -- NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

LONG-TERM CARE

Under current law, in certain counties, a person who meets certain functional and financial criteria and who is either a frail elder or a person who is at least 18 years old with a physical disability or a developmental disability is eligible for and may obtain the family care benefit. The family care benefit is financial assistance for long-term care.

Also, currently, an individual may be eligible for the family care benefit if he or she does not meet the functional eligibility requirements for the family care benefit but he or she 1) has a condition that is expected to last at least 90 days or result in death within 12 months, 2) applies within 36 months after the date on which the family care benefit is available in the individual's county of residence, and 3) on the date the family care benefit became available in the individual's county of residence, was a resident of a nursing home or had been receiving long-term care services under certain programs for at least 60 days. This bill eliminates this provision, thus requiring that all individuals meet the functional eligibility requirements to be eligible for family care.

Under current law, DHS must ensure that care management organizations have the capacity to provide the family care benefit within 24 months to all persons in the county who are entitled to it. This bill lengthens the period for ensuring the entitled benefit to 36 months.

Currently, a resource center in a county provides information on the family care benefit to certain individuals, provides functional and financial eligibility screenings to potential family care enrollees, and refers potential family care enrollees to a care management organization. A care management organization administers the family care benefit under a contract with DHS.

This bill allows care management organizations to administer either the Program of All-Inclusive Care for the Elderly (PACE) or the Wisconsin Partnership Program (Partnership), or both, in place of or in addition to the family care benefit. PACE and Partnership offer an integrated benefit, consisting of financial assistance for long-term care and support items, along with financial assistance for either acute or primary medical care or both. Under the bill, individuals obtaining the integrated benefit through PACE and Partnership have responsibilities, rights, and benefits similar to family care enrollees, such as contributing to the cost of care according to a formula; complying with divestment and trust rules; and contesting certain matters through a hearing process.

The bill imposes requirements on DHS, resource centers, care management organizations, and long-term care districts with respect to administration and implementation of the integrated benefit that are similar to the current requirements for administration and implementation of the family care benefit. For DHS these requirements include implementing a per person monthly rate structure for the costs of the integrated benefit; evaluating the client's opportunity to arrange for, manage, and monitor the integrated benefit; extending quality improvement efforts to the integrated benefit; and ensuring that resource centers and care management organizations establish procedures so that an integrated benefit applicant or enrollee may register a grievance. Resource centers must provide information about the integrated benefit and referral services to individuals who are potentially eligible for the integrated benefit. Care management organizations must designate whether they provide the integrated benefit, the family care benefit, or both; accept the reimbursement rate for the integrated benefit, if provided; contract for the provision of acute and primary care services with a provider that agrees to accept the reimbursement rate; accept the enrollment of a person eligible for the integrated benefit for whom funding is available; provide for the integrated benefit enrollee to manage and monitor the benefit; provide fee-for-service case management services for those who are functionally but not financially eligible for an integrated benefit; and fulfill additional requirements. A long-term care district may provide services related to services available under an integrated benefit. The long-term care district has duties including assuring compliance with the terms of a contract with a care management organization or a resource center. The bill does not eliminate any requirements for DHS, resource centers, care management organizations, or long-term care districts with respect to administration and implementation of family care.

Under current law, the Board on Aging and Long-Term Care must contract to provide advocacy services to actual or potential recipients of the family care benefit in a ratio of one advocate to every 2,500 individuals under age 60 who receive the family care benefit. DHS must allot $525,000 for the contract to provide advocacy services in each fiscal year. This bill decreases the ratio to one advocate to every 3,500 individuals under age 60 who receive either family care or the integrated benefit through PACE or Partnership. The bill eliminates the requirement for DHS to allot money for the contract.

Under current law, the county pays for services for a developmentally disabled individual if those services are not paid for by the federal government. The county also pays for certain mental health services that are not paid for by the federal government. If the individual receiving services is eligible for medical assistance, DHS will pay for the services not paid for by the federal government. This bill requires that, for individuals receiving the family care benefit, the care management organization pay for services provided to developmentally disabled individuals, including mental health services covered by family care.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 16.009 (2) (p) (intro.) of the statutes is amended to read:

16.009 **(2)** (p) (intro.) Employ staff within the classified service or contract with one or more organizations to provide advocacy services to potential or actual recipients of the family care benefit, as defined in s. 46.2805 (4), or of an integrated benefit, as defined in s. 46.2805 (7h), or their families or guardians. The board and contract organizations under this paragraph shall assist these persons in protecting their rights under all applicable federal statutes and regulations and state statutes and rules. An organization with which the board contracts for these services may not be a provider, nor an affiliate of a provider, of long-term care services, a resource center under s. 46.283 or a care management organization under s. 46.284. For potential or actual recipients of the family care benefit or an integrated benefit, advocacy services required under this paragraph shall include all of the following:

SECTION 2. 16.009 (2) (p) 5. of the statutes is amended to read:

16.009 **(2)** (p) 5. Providing individual case advocacy services in administrative hearings and legal representation for judicial proceedings regarding family care services or benefits or an integrated benefit.

SECTION 3. 20.435 (7) (g) of the statutes is amended to read:

20.435 **(7)** (g) *Long-term care; county contributions.* All moneys received from counties as contributions to the family care program under s. 46.2805 to 46.2895, the ~~Pace program~~ Program of All-Inclusive Care for the Elderly, as described under s. ~~46.2805 (1) (a)~~ 46.2805 (9m), and the Wisconsin Partnership Program described under s. ~~46.2805 (1) (b)~~ 46.2805 (15), to fund services under the family care benefit under s. 46.284 (5) and services under the ~~Pace~~ Program of All-Inclusive Care for the Elderly and the Wisconsin Partnership ~~programs~~ Program.

SECTION 4. 46.2803 (2) of the statutes is amended to read:

46.2803 **(2)** Notwithstanding s. 46.27 (7), a county in which a care management organization is operating pursuant to a contract under s. 46.284 (2) or a county in which a program described under s. ~~46.2805 (1) (a) or (b)~~ 46.2805 (9m) or (15) is administered may use funds appropriated under 20.435 (7) (bd) and allocated to the county under s. 46.27 (7) to provide community mental health or substance abuse services and supports for persons with mental illness or persons in need of services or supports for substance abuse and to provide services under the Family Support Program under s. 46.985.

SECTION 5. 46.2805 (1) (intro.) of the statutes is renumbered 46.2805 (1) and amended to read:

46.2805 **(1)** "Care management organization" means an entity that is certified as meeting the requirements for a care management organization under s. 46.284 (3) and that has a contract under s. 46.284 (2). ~~"Care management organization" does~~

~~not mean an entity that contracts with the department or a contract to operate one of the following:~~ to provide the family care benefit, an integrated benefit, or both.

SECTION 6. 46.2805 (1) (a) of the statutes is repealed.

SECTION 7. 46.2805 (1) (b) of the statutes is repealed.

SECTION 8. 46.2805 (7h) of the statutes is created to read:

46.2805 **(7h)** "Integrated benefit" means financial assistance for long-term care and support items, along with financial assistance for either acute or primary medical care or both for an enrollee.

SECTION 9. 46.2805 (9m) of the statutes is created to read:

46.2805 **(9m)** "Program of All-Inclusive Care for the Elderly" means the program operated under 42 USC 1395eee or 1396u-4 providing an integrated benefit.

SECTION 10. 46.2805 (15) of the statutes is created to read:

46.2805 **(15)** "Wisconsin Partnership Program" means a Medical Assistance demonstration program providing an integrated benefit.

SECTION 11. 46.281 (1d) of the statutes is amended to read:

46.281 **(1d)** WAIVER REQUEST. The department shall request from the secretary of the federal department of health and human services any waivers of federal medicaid laws necessary to permit the use of federal moneys to provide the family care benefit or an integrated benefit to recipients of medical assistance. The department shall implement any waiver that is approved and that is consistent with ss. 46.2805 to 46.2895. Regardless of whether a waiver is approved, the department may implement operation of resource centers, care management organizations, ~~and~~ the family care benefit, and an integrated benefit.

SECTION 12. 46.281 (1g) (a) of the statutes is amended to read:

46.281 **(1g)** (a) Subject to par. (b), the department may contract with entities as provided under s. 46.283 (2) to provide the services under s. 46.283 (3) and (4) as resource centers in any geographic area in the state, and may contract with entities as provided under s. 46.284 (2) to administer the family care benefit, an integrated benefit, or both as care management organizations in any geographic area in the state.

SECTION 13. 46.281 (1g) (b) of the statutes is amended to read:

46.281 **(1g)** (b) If the department proposes to contract with entities to administer the family care benefit or an integrated benefit in geographic areas in which, in the aggregate, resides more than 29 percent of the state population that is eligible for the family care benefit or an integrated benefit, the department shall first notify the joint committee on finance in writing of the proposed contract. The notification shall include the contract proposal; and an estimate of the fiscal impact of the proposed addition that demonstrates that the addition will be cost neutral, including startup, transitional, and ongoing operational costs and any proposed county contribution. The notification shall also include, for each county affected by the proposal, documentation that the county consents to administration of the family care benefit, an integrated benefit, or both in the county, the amount of the county's payment or reduction in community aids under s. 46.281 (4), and a proposal by the county for using any savings in county expenditures on long-term care that result from administration of the family care benefit or integrated benefit in the county. If the cochairpersons of the committee do not notify the department within 14 working days after the date of the department's notification that the committee has scheduled a meeting for the purpose of reviewing the proposed contract, the department may enter into the proposed contract. If within 14 working days after

the date of the department's notification the cochairpersons of the committee notify the department that the committee has scheduled a meeting for the purpose of reviewing the proposed contract, the department may enter into the proposed contract only if the committee approves the proposed contract or if the committee fails to act on the proposed contract within 59 working days after the date of the department's notification.

SECTION 14. 46.281 (1n) (a) of the statutes is amended to read:

46.281 **(1n)** (a) Prescribe and implement a per person monthly rate structure for costs of the family care benefit and an integrated benefit.

SECTION 15. 46.281 (1n) (b) 3. of the statutes is amended to read:

46.281 **(1n)** (b) 3. Conduct ongoing evaluations of managed care programs for provision of long-term care services that are funded by medical assistance, as defined in s. 46.278 (1m) (b), as to client access to services, the availability of client choice of living and service options, quality of care, and cost-effectiveness. In evaluating the availability of client choice, the department shall evaluate the opportunity for a client to arrange for, manage, and monitor his or her family care benefit or integrated benefit directly or with assistance, as specified in s. 46.284 (4) (e).

SECTION 16. 46.281 (1n) (b) 4. of the statutes is amended to read:

46.281 **(1n)** (b) 4. Require that quality assurance and quality improvement efforts be included throughout ~~the long-term care system specified in ss. 46.2805 to 46.2895~~ family care benefit or integrated benefit services.

SECTION 17. 46.281 (1n) (c) of the statutes is amended to read:

46.281 **(1n)** (c) Require by contract that resource centers and care management organizations establish procedures under which an individual who applies for or

receives the family care benefit or an integrated benefit may register a complaint or grievance and procedures for resolving complaints and grievances.

SECTION 18. 46.281 (1n) (e) of the statutes is amended to read:

46.281 **(1n)** (e) Contract with a person to provide the advocacy services described under s. 16.009 (2) (p) 1. to 5. to actual or potential recipients of the family care benefit or an integrated benefit who are under age 60 or to their families or guardians. The department may not contract under this paragraph with a county or with a person who has a contract with the department to provide services under s. 46.283 (3) and (4) as a resource center or to administer the family care benefit or an integrated benefit as a care management organization. The contract under this paragraph shall include as a goal that the provider of advocacy services provide one advocate for every ~~2,500~~ 3,500 individuals under age 60 who receive the family care or an integrated benefit. ~~The department shall allocate $190,000 for the contract under this paragraph in fiscal year 2007-08 and $525,000 in each subsequent fiscal year.~~

SECTION 19. 46.2825 (2) (a) of the statutes is amended to read:

46.2825 **(2)** (a) Evaluate the performance of care management organizations ~~and entities that operate a program described under s. 46.2805 (1) (a) or (b)~~ in the committee's region with respect to responsiveness to recipients of their services, fostering choices for recipients, and other issues affecting recipients; and make recommendations based on the evaluation to the department and to the care management organizations and entities, as appropriate.

SECTION 20. 46.2825 (2) (c) of the statutes is amended to read:

46.2825 **(2)** (c) Monitor grievances and appeals made to care management organizations ~~or entities that operate a program described under s. 46.2805 (1) (a) or (b)~~ within the committee's region.

SECTION 21. 46.283 (1) (a) 1. of the statutes is amended to read:

46.283 **(1)** (a) 1. Whether to authorize one or more county departments under s. 46.21, 46.215, 46.22 or 46.23 or an aging unit under s. 46.82 (1) (a) 1. or 2. to apply to the department for a contract to operate a resource center and, if so, which to authorize ~~and~~, what client group to serve, and whether to provide the family care benefit, an integrated benefit, or both.

SECTION 22. 46.283 (3) (f) of the statutes is amended to read:

46.283 **(3)** (f) Assistance to a person who is eligible for the family care benefit or an integrated benefit with respect to the person's choice of whether ~~or not~~ to enroll in a care management organization and, if so, which available care management organization would best meet his or her needs.

SECTION 23. 46.283 (4) (e) of the statutes is amended to read:

46.283 **(4)** (e) Provide information about the services of the resource center, including the services specified in sub. (3) (d), about assessments under s. 46.284 (4) (b) and care plans under s. 46.284 (4) (c) and about the family care benefit and an integrated benefit, if available in the area, to all older persons and persons with a physical disability who are residents of nursing homes, community-based residential facilities, adult family homes, and residential care apartment complexes in the area of the resource center.

SECTION 24. 46.283 (6) (a) 3. of the statutes is amended to read:

46.283 **(6)** (a) 3. An individual who has a financial interest in, or serves on the governing board of, a care management organization ~~or an organization that~~

~~administers a program described under s. 46.2805 (1) (a) or (b)~~ or a managed care program under s. 49.45 for individuals who are eligible to receive supplemental security income under 42 USC 1381 to 1383c, which serves any geographic area also served by a resource center, and the individual's family members, may not serve as members of the governing board of the resource center.

SECTION 25. 46.284 (1) (a) 1. of the statutes is amended to read:

46.284 **(1)** (a) 1. Whether to authorize one or more county departments under s. 46.21, 46.215, 46.22 or 46.23 or an aging unit under s. 46.82 (1) (a) 1. or 2. to apply to the department for a contract to operate a care management organization and, if so, which to authorize ~~and~~, what client group to serve, and whether to provide the family care benefit, an integrated benefit, or both.

SECTION 26. 46.284 (1) (b) of the statutes is amended to read:

46.284 **(1)** (b) The governing body of a tribe or band or of the Great Lakes Inter-Tribal Council, Inc., may decide whether to authorize a tribal agency to apply to the department for a contract to operate a care management organization for tribal members and, if so, which client group to serve and whether to provide the family care benefit, an integrated benefit, or both.

SECTION 27. 46.284 (2) (c) of the statutes is renumbered 46.284 (2) (c) (intro.) and amended to read:

46.284 **(2)** (c) (intro.) The department shall require, as a term of any contract with a care management organization under this section, ~~that~~ all of the following:

2. That the care management organization contract for the provision of long-term care services that are covered under the family care or integrated benefit with any community-based residential facility under s. 50.01 (1g), residential care apartment complex under s. 50.01 (1d), nursing home under s. 50.01 (3),

intermediate care facility for the mentally retarded under s. 50.14 (1) (b), community rehabilitation program, home health agency under s. 50.49 (1) (a), provider of day services, or provider of personal care, as defined in s. 50.01 (4o), that agrees to accept the reimbursement rate that the care management organization pays under contract to similar providers for the same service and that satisfies any applicable quality of care, utilization, or other criteria that the care management organization requires of other providers with which it contracts to provide the same service.

SECTION 28. 46.284 (2) (c) 1. of the statutes is created to read:

46.284 **(2)** (c) 1. That the care management organization designate whether it provides the family care benefit, an integrated benefit, or both.

SECTION 29. 46.284 (2) (c) 3. of the statutes is created to read:

46.284 **(2)** (c) 3. That the care management organization contract for the provision of acute and primary care services covered under an integrated benefit with a provider that agrees to accept the reimbursement rate the care management organization pays under contract to similar providers for the same service and that satisfies any applicable quality of care, utilization, or other criteria the care management organization requires of other providers with which it contracts to provide the same service.

SECTION 30. 46.284 (4) (a) of the statutes is amended to read:

46.284 **(4)** (a) Accept requested enrollment of any person who is entitled to the family care benefit and of any person for whom funding is available and who is eligible for the family care benefit ~~and for whom funding is available~~ or an integrated benefit, whichever the care management organization is contracted to provide. No care management organization may disenroll any enrollee, except under circumstances specified by the department by contract. No care management

organization may encourage any enrollee to disenroll in order to obtain long-term care services under the medical assistance fee-for-service system. No involuntary disenrollment is effective unless the department has reviewed and approved it.

SECTION 31. 46.284 (4) (e) of the statutes is amended to read:

46.284 **(4)** (e) Provide, within guidelines established by the department, a mechanism by which an enrollee may arrange for, manage, and monitor his or her family care benefit or an integrated benefit directly or with the assistance of another person chosen by the enrollee. The care management organization shall provide each enrollee with a form on which the enrollee shall indicate whether he or she has been offered the option under this paragraph and whether he or she has accepted or declined the option. If the enrollee accepts the option, the care management organization shall monitor the enrollee's use of a fixed budget for purchase of services or support items from any qualified provider, monitor the health and safety of the enrollee, and provide assistance in management of the enrollee's budget and services at a level tailored to the enrollee's need and desire for the assistance.

SECTION 32. 46.284 (4) (f) of the statutes is amended to read:

46.284 **(4)** (f) Provide, on a fee-for-service basis, case management services to persons who are functionally eligible but not financially eligible for the family care benefit or an integrated benefit.

SECTION 33. 46.284 (5) (a) of the statutes is amended to read:

46.284 **(5)** (a) From the appropriation accounts under s. 20.435 (4) (b), (g), (gp), (im), (o), and (w) and (7) (b), (bd), and (g), the department shall provide funding on a capitated payment basis for the provision of services under this section. Notwithstanding s. 46.036 (3) and (5m), a care management organization that is under contract with the department may expend the funds, consistent with this

section, including providing payment, on a capitated basis, to providers of services under the family care benefit or an integrated benefit.

SECTION 34. 46.284 (5) (d) 4. of the statutes is amended to read:

46.284 **(5)** (d) 4. The requirement that a care management organization place funds in a risk reserve and maintain the risk reserve in an interest-bearing escrow account with a financial institution, as defined in s. 69.30 (1) (b), or invest funds as specified in s. 46.2895 (4) (j) 2. or 3. Moneys in the risk reserve or invested as specified in this subdivision may be expended only for the provision of services under this section. If a care management organization ceases participation under this section, the funds in the risk reserve or invested as specified in this subdivision, minus any contribution of moneys other than those specified in par. (c), shall be returned to the department. The department shall expend the moneys for the payment of outstanding debts to providers of family care benefit or integrated benefit services and for the continuation of family care benefit and integrated benefit services to enrollees.

SECTION 35. 46.284 (5) (e) 1. of the statutes is amended to read:

46.284 **(5)** (e) 1. Subject to subd. 2., a care management organization may enter into contracts with providers of family care benefit or integrated benefit services and may limit profits of the providers under the contracts.

SECTION 36. 46.286 (title) of the statutes is amended to read:

46.286 (title) **Family care benefit and integrated benefit.**

SECTION 37. 46.286 (1) (title) of the statutes is repealed and recreated to read:

46.286 **(1)** (title) FAMILY CARE ELIGIBILITY.

SECTION 38. 46.286 (1) (a) (intro.) and 46.286 (1) (a) 1. (intro.) of the statutes are consolidated, renumbered 46.286 (1) (a) (intro.) and amended to read:

46.286 **(1)** (a) *Functional eligibility.* (intro.) A person is functionally eligible if ~~any of the following applies~~ the person's level of care need, as determined by the department or its designee~~: 1. (intro.) The person's level of care need,~~ is either of the following:

SECTION 39. 46.286 (1) (a) 1. a. of the statutes is renumbered 46.286 (1) (a) 1m.

SECTION 40. 46.286 (1) (a) 1. b. of the statutes is renumbered 46.286 (1) (a) 2m.

SECTION 41. 46.286 (1) (a) 2. (intro.) of the statutes is repealed.

SECTION 42. 46.286 (1) (a) 2. a. of the statutes is renumbered 46.286 (3) (b) 2. a.

SECTION 43. 46.286 (1) (a) 2. b. of the statutes is renumbered 46.286 (3) (b) 2. b.

SECTION 44. 46.286 (1) (a) 2. c. of the statutes is renumbered 46.286 (3) (b) 2. c.

SECTION 45. 46.286 (1) (a) 2. d. of the statutes is renumbered 46.286 (3) (b) 2. d.

SECTION 46. 46.286 (1) (a) 2. e. of the statutes is renumbered 46.286 (3) (b) 2. e.

SECTION 47. 46.286 (2) (a) of the statutes is amended to read:

46.286 **(2)** (a) A person who is determined to be financially eligible ~~under sub. (1) (b)~~ for family care, the Program of All-Inclusive Care for the Elderly, or the Wisconsin Partnership Program shall contribute to the cost of his or her care an amount that is calculated by the department or its designee after subtracting from the person's gross income, plus one-twelfth of countable assets, the deductions and allowances permitted by the department by rule.

SECTION 48. 46.286 (2) (b) of the statutes is amended to read:

46.286 **(2)** (b) Funds received under par. (a) shall be used by a care management organization to pay for services under the family care benefit, the Program of All-Inclusive Care for the Elderly, or the Wisconsin Partnership Program from whichever program the person is receiving services.

SECTION 49. 46.286 (2) (c) of the statutes is amended to read:

46.286 **(2)** (c) A person who is required to contribute to the cost of his or her care but who fails to make the required contributions is ineligible for the family care benefit, the Program of All-Inclusive Care for the Elderly, and the Wisconsin Partnership Program unless he or she is exempt from the requirement under rules promulgated by the department.

SECTION 50. 46.286 (3) (title) of the statutes is repealed and recreated to read:

46.286 **(3)** (title) FAMILY CARE ENTITLEMENT.

SECTION 51. 46.286 (3) (b) 2. of the statutes is renumbered 46.286 (3) (b) 2. (intro.) and amended to read:

46.286 **(3)** (b) 2. (intro.) If the contract between the care management organization and the department is canceled or not renewed. If this circumstance occurs, the department shall assure that enrollees continue to receive needed services through another care management organization or through the medical assistance fee-for-service system or any of the following programs ~~specified under sub. (1) (a) 2. a. to d.~~:

SECTION 52. 46.286 (3) (c) of the statutes is amended to read:

46.286 **(3)** (c) Within each county and for each client group, par. (a) shall first apply on the effective date of a contract under which a care management organization accepts a per person per month payment to provide services under the family care benefit to eligible persons in that client group in the county. Within ~~24~~

36 months after this date, the department shall assure that sufficient capacity exists within one or more care management organizations to provide the family care benefit to all entitled persons in that client group in the county.

SECTION 53. 46.286 (3m) of the statutes is amended to read:

46.286 **(3m)** INFORMATION ABOUT ENROLLEES. The department shall obtain and share information about family care benefit and integrated benefit enrollees as provided in s. 49.475.

SECTION 54. 46.286 (4) of the statutes is amended to read:

46.286 **(4)** DIVESTMENT; RULES. The department shall promulgate rules, which are substantially similar to applicable provisions under s. 49.453, relating to prohibitions on divestment of assets of persons who receive the family care benefit, ~~that are substantially similar to applicable provisions under s. 49.453~~ or an integrated benefit.

SECTION 55. 46.286 (5) of the statutes is amended to read:

46.286 **(5)** TREATMENT OF TRUST AMOUNTS; RULES. The department shall promulgate rules, which are substantially similar to applicable provisions under s. 49.454, relating to treatment of trust amounts of persons who receive the family care benefit, ~~that are substantially similar to applicable provisions under s. 49.454~~ or an integrated benefit.

SECTION 56. 46.286 (6) of the statutes is amended to read:

46.286 **(6)** PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE; RULES. The department shall promulgate rules, which are substantially similar to applicable provisions under s. 49.455 relating to protection of income and resources of couples for the maintenance of the spouse in the community with regard to persons who receive the family care benefit, ~~that are~~

~~substantially similar to applicable provisions under s. 49.455~~ or an integrated benefit.

SECTION 57. 46.286 (7) of the statutes is amended to read:

46.286 **(7)** RECOVERY OF FAMILY CARE BENEFIT PAYMENTS; RULES. The department shall promulgate rules, which are substantially similar to applicable provisions under ss. 49.496 and 49.497, relating to the recovery from persons who receive the family care benefit, including by liens and from estates, of correctly and incorrectly paid family care benefits ~~that are substantially similar to applicable provisions under ss. 49.496 and 49.497~~ and integrated benefits.

SECTION 58. 46.287 (1) of the statutes is amended to read:

46.287 **(1)** DEFINITION. In this section, "client" means a person applying for eligibility for the family care benefit or an integrated benefit, an eligible person, or an enrollee.

SECTION 59. 46.287 (2) (a) 1. e. of the statutes is amended to read:

46.287 **(2)** (a) 1. e. Reduction of services or support items under the family care benefit or an integrated benefit.

SECTION 60. 46.287 (2) (a) 1. g. of the statutes is amended to read:

46.287 **(2)** (a) 1. g. Termination of the family care benefit or an integrated benefit.

SECTION 61. 46.287 (2) (a) 1. h. of the statutes is amended to read:

46.287 **(2)** (a) 1. h. Imposition of ineligibility for the family care benefit or an integrated benefit under s. 46.286 (4).

SECTION 62. 46.287 (2) (a) 1. k. of the statutes is amended to read:

46.287 **(2)** (a) 1. k. Recovery of family care benefit or integrated benefit payments under s. 46.286 (7).

SECTION 63. 46.288 (2) (intro.) of the statutes is amended to read:

46.288 **(2)** (intro.) Criteria and procedures for determining functional eligibility under s. 46.286 (1) (a), financial eligibility under s. 46.286 (1) (b), and cost sharing under s. 46.286 (2) (a). The rules for determining functional eligibility under s. 46.286 (1) (a) ~~1. a.~~ 1m. shall be substantially similar to eligibility criteria for receipt of the long-term support community options program under s. 46.27. Rules under this subsection shall include definitions of the following terms applicable to s. 46.286:

SECTION 64. 46.288 (2) (a) of the statutes is repealed.

SECTION 65. 46.288 (2) (b) of the statutes is repealed.

SECTION 66. 46.288 (2) (c) of the statutes is repealed.

SECTION 67. 46.2895 (1) (a) 1. b. of the statutes is amended to read:

46.2895 **(1)** (a) 1. b. Specifies the long-term care district's primary purpose, which shall be to operate, under contract with the department, a resource center under s. 46.283, or a care management organization under s. 46.284~~, or a program described under s. 46.2805 (1) (a) or (b)~~.

SECTION 68. 46.2895 (1) (c) of the statutes is amended to read:

46.2895 **(1)** (c) A long-term care district may not operate a care management organization under s. 46.284 ~~or a program described under s. 46.2805 (1) (a) or (b)~~ if the district operates a resource center under s. 46.283.

SECTION 69. 46.2895 (4) (b) of the statutes is amended to read:

46.2895 **(4)** (b) Adopt bylaws and policies and procedures for the regulation of its affairs and the conduct of its business. The bylaws, policies and procedures shall be consistent with ss. 46.2805 to 46.2895 and, if the long-term care district contracts with the department under par. (d) ~~or (dm)~~, with the terms of that contract.

SECTION 70. 46.2895 (4) (dm) of the statutes is repealed.

SECTION 71. 46.2895 (4) (e) of the statutes is amended to read:

46.2895 **(4)** (e) Provide services related to services available under the family care benefit or an integrated benefit, to older persons and persons with disabilities, in addition to the services funded under the contract with the department that is specified under par. (d).

SECTION 72. 46.2895 (6) (c) of the statutes is amended to read:

46.2895 **(6)** (c) Assure compliance with the terms of any contract with the department under sub. (4) (d) ~~or (dm)~~.

SECTION 73. 49.45 (30m) (am) of the statutes is renumbered 49.45 (30m) (am) 1.

SECTION 74. 49.45 (30m) (am) 2. of the statutes is created to read:

49.45 **(30m)** (am) 2. For individuals receiving the family care benefit under s. 46.286, the care management organization that manages the family care benefit for the recipient shall pay the portion of the payment that is not covered by the federal government for services that are described under par. (a) 1. and are covered services under the family care benefit; the department shall pay the remainder of the portion of the payment that is not covered by the federal government.

SECTION 75. 49.475 (1) (e) 2. of the statutes is amended to read:

49.475 **(1)** (e) 2. An enrollee of family care, the Program of All-Inclusive Care for the Elderly, as defined in s. 46.2805 (9m), or the Wisconsin Partnership Program, as defined in s. 46.2805 (15).

SECTION 76. 50.49 (6m) (b) of the statutes is repealed.

SECTION 77. 50.49 (6m) (c) of the statutes is repealed.

SECTION 78. 51.437 (4rm) (d) of the statutes is created to read:

51.437 **(4rm)** (d) Notwithstanding pars. (a) to (c), for individuals receiving the family care benefit under s. 46.286, the care management organization that manages the family care benefit for the recipient shall pay the portion of the payment that is for services that are covered under the family care benefit; the department shall pay the remainder of the payment.

SECTION 9322. Initial applicability; Health Services.

(1) FAMILY CARE ENTITLEMENT. The treatment of section 46.286 (3) (c) of the statutes first applies to care management organizations that implement the family care benefit on January 1, 2008.

(END)

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-0376/P3 P4
TJD:wlj:ph

In: 1/30/09

RMNR

DOA:.....Willing, BB0090 – Family care eligibility, disability ombudsman, intensive treatment program charge-backs, rule-making changes

FOR 2009-11 BUDGET -- NOT READY FOR INTRODUCTION

Do Not Gen

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

LONG-TERM CARE

Under current law, in certain counties, a person who meets certain functional and financial criteria and who is either a frail elder or a person who is at least 18 years old with a physical disability or a developmental disability is eligible for and may obtain the family care benefit. The family care benefit is financial assistance for long-term care.

Also, currently, an individual may be eligible for the family care benefit if he or she does not meet the functional eligibility requirements for the family care benefit but he or she 1) has a condition that is expected to last at least 90 days or result in death within 12 months, 2) applies within 36 months after the date on which the family care benefit is available in the individual's county of residence, and 3) on the date the family care benefit became available in the individual's county of residence, was a resident of a nursing home or had been receiving long-term care services under certain programs for at least 60 days. This bill eliminates this provision, thus requiring that all individuals meet the functional eligibility requirements to be eligible for family care.

Under current law, a care management organization administers the family care benefit under a contract with DHS. DHS must ensure that care management organizations have the capacity to provide the family care benefit within 24 months to all persons in the county who are entitled to it. This bill lengthens the period for ensuring the entitled benefit to 36 months.

Under current law, the Board on Aging and Long-Term Care must contract to provide advocacy services to actual or potential recipients of the family care benefit in a ratio of one advocate to every 2,500 individuals under age 60 who receive the family care benefit. DHS must allot $525,000 for the contract to provide advocacy services in each fiscal year. This bill decreases the ratio to one advocate to every 3,500 individuals under age 60 who receive the family care benefit. The bill eliminates the requirement for DHS to allot money for the contract.

Under current law, the county pays for services for a developmentally disabled individual if those services are not paid for by the federal government. The county also pays for certain mental health services that are not paid for by the federal government. If the individual receiving services is eligible for medical assistance, DHS will pay for the services not paid for by the federal government. This bill requires that, for individuals receiving the family care benefit, the care management organization pay for services provided to developmentally disabled individuals, including mental health services covered by family care.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 46.281 (1n) (e) of the statutes is amended to read:

46.281 **(1n)** (e) Contract with a person to provide the advocacy services described under s. 16.009 (2) (p) 1. to 5. to actual or potential recipients of the family care benefit who are under age 60 or to their families or guardians. The department may not contract under this paragraph with a county or with a person who has a contract with the department to provide services under s. 46.283 (3) and (4) as a resource center or to administer the family care benefit as a care management organization. The contract under this paragraph shall include as a goal that the provider of advocacy services provide one advocate for every ~~2,500~~ 3,500 individuals under age 60 who receive the family care benefit. ~~The department shall allocate~~

~~$190,000 for the contract under this paragraph in fiscal year 2007-08 and $525,000 in each subsequent fiscal year.~~

SECTION 2. 46.286 (1) (a) (intro.) and 1. (intro.) of the statutes are consolidated, renumbered 46.286 (1) (a) (intro.) and amended to read:

46.286 **(1)** (a) *Functional eligibility.* (intro.) A person is functionally eligible if ~~any of the following applies~~ the person's level of care need, as determined by the department or its designee~~: 1. (intro.) The person's level of care need,~~ is either of the following:

SECTION 3. 46.286 (1) (a) 1. a. of the statutes is renumbered 46.286 (1) (a) 1m.

SECTION 4. 46.286 (1) (a) 1. b. of the statutes is renumbered 46.286 (1) (a) 2m.

SECTION 5. 46.286 (1) (a) 2. (intro.) of the statutes is repealed.

SECTION 6. 46.286 (1) (a) 2. a. of the statutes is renumbered 46.286 (3) (b) 2. a.

SECTION 7. 46.286 (1) (a) 2. b. of the statutes is renumbered 46.286 (3) (b) 2. b.

SECTION 8. 46.286 (1) (a) 2. c. of the statutes is renumbered 46.286 (3) (b) 2. c.

SECTION 9. 46.286 (1) (a) 2. d. of the statutes is renumbered 46.286 (3) (b) 2. d.

SECTION 10. 46.286 (1) (a) 2. e. of the statutes is renumbered 46.286 (3) (b) 2. e.

SECTION 11. 46.286 (3) (b) 2. of the statutes is renumbered 46.286 (3) (b) 2. (intro.) and amended to read:

46.286 **(3)** (b) 2. (intro.) If the contract between the care management organization and the department is canceled or not renewed. If this circumstance occurs, the department shall assure that enrollees continue to receive needed services through another care management organization or through the medical assistance fee-for-service system or any of the following programs ~~specified under sub. (1) (a) 2. a. to d.~~:

SECTION 12. 46.286 (3) (c) of the statutes is amended to read:

46.286 **(3)** (c) Within each county and for each client group, par. (a) shall first apply on the effective date of a contract under which a care management organization accepts a per person per month payment to provide services under the family care benefit to eligible persons in that client group in the county. Within ~~24~~ 36 months after this date, the department shall assure that sufficient capacity exists within one or more care management organizations to provide the family care benefit to all entitled persons in that client group in the county.

****NOTE: Do you still want to change the deadline? I don't believe this was part of the original request.

SECTION 13. 46.288 (2) (intro.) of the statutes is amended to read:

46.288 **(2)** (intro.) Criteria and procedures for determining functional eligibility under s. 46.286 (1) (a), financial eligibility under s. 46.286 (1) (b), and cost sharing under s. 46.286 (2) (a). The rules for determining functional eligibility under s. 46.286 (1) (a) ~~1. a.~~ 1m. shall be substantially similar to eligibility criteria for receipt of the long-term support community options program under s. 46.27. Rules under this subsection shall include definitions of the following terms applicable to s. 46.286:

SECTION 14. 46.288 (2) (a) of the statutes is repealed.

SECTION 15. 46.288 (2) (b) of the statutes is repealed.

SECTION 16. 46.288 (2) (c) of the statutes is repealed.

SECTION 17. 49.45 (30m) (am) of the statutes is renumbered 49.45 (30m) (am) 1.

SECTION 18. 49.45 (30m) (am) 2. of the statutes is created to read:

49.45 **(30m)** (am) 2. For individuals receiving the family care benefit under s. 46.286, the care management organization that manages the family care benefit for

the recipient shall pay the portion of the payment that is not covered by the federal government for services that are described under par. (a) 1. and are covered services under the family care benefit; the department shall pay the remainder of the portion of the payment that is not covered by the federal government.

SECTION 19. 51.437 (4rm) (d) of the statutes is created to read:

51.437 **(4rm)** (d) Notwithstanding pars. (a) to (c), for individuals receiving the family care benefit under s. 46.286, the care management organization that manages the family care benefit for the recipient shall pay the portion of the payment that is for services that are covered under the family care benefit; the department shall pay the remainder of the payment.

SECTION 9322. Initial applicability; Health Services.

(1) FAMILY CARE ENTITLEMENT. The treatment of section 46.286 (3) (c) of the statutes first applies to care management organizations that implement the family care benefit on January 1, 2008.

(END)

State of Wisconsin
2009 - 2010 LEGISLATURE

LRB-0376/P4
TJD:wlj:rs

DOA:.....Willing, BB0090 - Family care eligibility, disability ombudsman, intensive treatment program charge-backs, rule-making changes

FOR 2009-11 BUDGET -- NOT READY FOR INTRODUCTION

AN ACT ...; **relating to:** the budget.

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LONG-TERM CARE

Under current law, in certain counties, a person who meets certain functional and financial criteria and who is either a frail elder or a person who is at least 18 years old with a physical disability or a developmental disability is eligible for and may obtain the family care benefit. The family care benefit is financial assistance for long-term care.

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SECTION 4. 46.286 (1) (a) 1. b. of the statutes is renumbered 46.286 (1) (a) 2m.

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SECTION 6. 46.286 (1) (a) 2. a. of the statutes is renumbered 46.286 (3) (b) 2. a.

SECTION 7. 46.286 (1) (a) 2. b. of the statutes is renumbered 46.286 (3) (b) 2. b.

SECTION 8. 46.286 (1) (a) 2. c. of the statutes is renumbered 46.286 (3) (b) 2. c.

SECTION 9. 46.286 (1) (a) 2. d. of the statutes is renumbered 46.286 (3) (b) 2. d.

SECTION 10. 46.286 (1) (a) 2. e. of the statutes is renumbered 46.286 (3) (b) 2. e.

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46.286 **(3)** (b) 2. (intro.) If the contract between the care management organization and the department is canceled or not renewed. If this circumstance occurs, the department shall assure that enrollees continue to receive needed services through another care management organization or through the medical assistance fee-for-service system or any of the following programs ~~specified under sub. (1) (a) 2. a. to d.~~:

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49.45 **(30m)** (am) 2. For individuals receiving the family care benefit under s. 46.286, the care management organization that manages the family care benefit for the recipient shall pay the portion of the payment that is not covered by the federal government for services that are described under par. (a) 1. and are covered services

under the family care benefit; the department shall pay the remainder of the portion of the payment that is not covered by the federal government.

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51.437 **(4rm)** (d) Notwithstanding pars. (a) to (c), for individuals receiving the family care benefit under s. 46.286, the care management organization that manages the family care benefit for the recipient shall pay the portion of the payment that is for services that are covered under the family care benefit; the department shall pay the remainder of the payment.

SECTION 9322. Initial applicability; Health Services.

(1) FAMILY CARE ENTITLEMENT. The treatment of section 46.286 (3) (c) of the statutes first applies to care management organizations that implement the family care benefit on January 1, 2008.

(END)